Washington State Department of Health

Immediately notify DOH Communicable Disease Epidemiology Phone: 877-539-4344

Measles

County

LHJ Use ID _____
☐ Reported to DOH Date ___/___/___
LHJ Classification ☐ Confirmed ☐ Probable
By: ☐ Lab ☐ Clinical ☐ Epi Link: _____

☐ **Outbreak-related**
*LHJ Cluster#*_____
LHJ Cluster Name: _____
DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation start date: ___/___/___

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name _____
Zip code (school or occupation): _____ Phone _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Fever** Highest measured temp: _____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
Onset date: ___/___/___ Duration ___days

☐ ☐ ☐ ☐ **Runny nose (coryza)** Onset date: ___/___/___

☐ ☐ ☐ ☐ **Cough** Onset date: ___/___/___

☐ ☐ ☐ ☐ **Rash** Onset date ___/___/___ Duration ___days
Flat spots __ Raised spots __ Both __
Blisters/Pustules __ Blotchy __ Color: _____
Where did it first appear? _____
Rash progression: _____
Where was it most intense? _____
Does the rash itch? Yes__ No__

☐ ☐ ☐ ☐ Sore throat Onset date: ___/___/___

☐ ☐ ☐ ☐ Seizures new with disease Onset: ___/___/___

☐ ☐ ☐ ☐ Diarrhea Onset date: ___/___/___

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ **Conjunctivitis**

☐ ☐ ☐ ☐ **Koplik spots**

☐ ☐ ☐ ☐ **Rash observed by health care provider**
Rash distribution: _____
☐Generalized ☐Localized ☐On palms and soles
☐Petechial ☐ Macular ☐ Papular
☐Pustular ☐Vesicular ☐Bullous
☐Other: _____

☐ ☐ ☐ ☐ Photophobia

☐ ☐ ☐ ☐ Otitis media

☐ ☐ ☐ ☐ Pneumonia or pneumonitis

☐ ☐ ☐ ☐ Encephalitis or encephalomyelitis

☐ ☐ ☐ ☐ Lymphadenopathy Onset date: ___/___/___
☐Cervical ☐Suboccipital
☐Postauricular ☐Other: _____

☐ ☐ ☐ ☐ Thrombocytopenia

☐ ☐ ☐ ☐ Complications
Specify: _____

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness
Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ___/___/___

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ Ever received measles containing vaccine
Dose 1 Type: _____ Date received: ___/___/___
Dose 2 Type: _____ Date received: ___/___/___
Dose 3 Type: _____ Date received: ___/___/___

☐ ☐ ☐ ☐ Vaccine up to date for measles
Number of doses on or after the 1st birthday:_____
Number of doses before the 1st birthday:_____
Vaccine series not up to date reason:
☐ Religious exemption ☐ Medical contraindication
☐ Philosophical exemption
☐ Previous infection confirmed by laboratory
☐ Previous infection confirmed by physician
☐ Parental refusal ☐ Other:_____ ☐ Unk

Laboratory

Collection date ___/___/___
Source _____

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

P N I O NT

☐ ☐ ☐ ☐ ☐ **Measles virus culture (from blood or nasopharyngeal mucosal swab before day 4 of rash, or urine specimen before day 8 of rash)**

☐ ☐ ☐ ☐ ☐ **Measles IgG with significant rise (acute and convalescent serum pair)**

☐ ☐ ☐ ☐ ☐ **Measles IgM (serum ≥ 4 days after rash onset)**

☐ ☐ ☐ ☐ ☐ **Measles virus nucleic acid detection (PCR)**

☐ ☐ ☐ ☐ ☐ Tests to rule out other agents
Agent/results: _____ Date: ___/___/___
Agent/results: _____ Date: ___/___/___

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

Enter prodromal fever and rash onset dates. Count forward and backward to figure probable exposure and contagious periods.

	Exposure period		**PRODROME onset**	**RASH onset**	***Contagious period***
Days from fever onset:	-21	-7			4-5 days prior to rash onset to 4 days after rash onset
Calendar dates:					

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____

☐ ☐ ☐ ☐ Contact with recent foreign arrival
Specify country: _____

☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ ☐ ☐ ☐ Traceable within 2 generations to internat'l import

☐ ☐ ☐ ☐ Visited or worked in health care setting 1 - 3 weeks preceding onset
Facility name: _____
Number of visits: _____ Date(s): ___/___/___

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed or probable case**

Y N DK NA

☐ ☐ ☐ ☐ Attended gathering 1 - 3 weeks preceding onset

☐ ☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____

☐ ☐ ☐ ☐ Exposure setting identified:
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel
☐ Other, specify: _____ ☐ Unknown

☐ ☐ ☐ ☐ Antibiotic use in the week before rash onset:
Specify: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ **No risk factors or exposures could be identified**
☐ **Patient could not be interviewed**

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool

☐ ☐ ☐ ☐ Employed in child care or preschool

☐ ☐ ☐ ☐ Do any household members work at or attend child care or preschool

☐ ☐ ☐ ☐ Work/volunteer in health care setting while contagious: Facility name: _____

☐ ☐ ☐ ☐ Visited health care setting while contagious
Facility name: _____
Number of visits: _____ Date(s): ___/___/___

☐ ☐ ☐ ☐ Documented transmission from this case
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient clinic ☐ Home
☐ College ☐ Work ☐ Military
☐ Correction facility ☐ Church
☐ International travel ☐ Other: _____ ☐ Unk

PUBLIC HEALTH ACTIONS

☐ Exclude case from sensitive occupations or situations during contagious period

☐ Evaluate immune status of close contacts

☐ Prophylaxis of appropriate contacts recommended
Number of contacts recommended prophylaxis: _____
Number of contacts receiving prophylaxis: _____
Number of contacts completing prophylaxis: _____

☐ Exclude exposed susceptibles from work/school for incubation period

☐ Respiratory isolation in a health care setting

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____ **Record complete date** ___/___/___

Measles: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered